

State of Arizona
Senate
Forty-seventh Legislature
Second Regular Session
2006

SENATE BILL 1154

AN ACT

AMENDING SECTION 20-2510, ARIZONA REVISED STATUTES; RELATING TO HEALTH CARE INSURERS.

(TEXT OF BILL BEGINS ON NEXT PAGE)

1 Be it enacted by the Legislature of the State of Arizona:
2 Section 1. Section 20-2510, Arizona Revised Statutes, is amended to
3 read:

4 20-2510. Health care insurers requirements: medical directors

5 A. A health care insurer that proposes to provide coverage of
6 inpatient hospital and medical benefits, outpatient surgical benefits or any
7 medical, surgical or health care service for residents of this state with
8 utilization review of those benefits shall meet at least one of the following
9 requirements:

10 1. Have a certificate issued pursuant to this chapter.

11 2. Be accredited by the utilization review accreditation commission,
12 the national committee for quality assurance or any other nationally
13 recognized accreditation process recognized by the director.

14 3. Contract with a utilization review agent that has a certificate
15 issued pursuant to this chapter.

16 4. Contract with a utilization review agent that is accredited by the
17 utilization review accreditation commission, the national committee for
18 quality assurance or any other nationally recognized accreditation process
19 recognized by the director.

20 5. Provide to the director a signed and notarized statement that the
21 health care insurer has submitted an application for accreditation to the
22 utilization review accreditation commission or the national committee for
23 quality assurance and is awaiting completion of the accreditation review
24 process. On completion of the accreditation review process, the insurer
25 shall provide to the director adequate proof that the insurer has been
26 accredited. If the insurer is denied accreditation, within sixty days after
27 the denial the insurer shall meet at least one of the requirements set forth
28 in paragraph 1, 2, 3 or 4 of this subsection.

29 B. Except as provided in subsections C, ~~and~~ D AND E of this section,
30 any direct denial of prior authorization of a service requested by a health
31 care provider on the basis of medical necessity by a health care insurer
32 shall be made in writing by a medical director who holds an active
33 unrestricted license to practice medicine in this state pursuant to title 32,
34 chapter 13 or 17. The written denial shall include an explanation of why the
35 treatment was denied, and the medical director who made the denial shall sign
36 the written denial. The health care insurer shall send a copy of the written
37 denial to the health care provider who requested the treatment. Health care
38 insurers shall maintain copies of all written denials and shall make the
39 copies available to the department for inspection during regular business
40 hours. The medical director is responsible for all direct denials that are
41 made on the basis of medical necessity. Nothing in this section prohibits a
42 health care insurer from consulting with a licensed physician whose scope of
43 practice may provide the health care insurer with a more thorough review of
44 the medical necessity.

1 C. For determinations made pursuant to subsection B of this section, a
2 dental service corporation as defined in section 20-822 or a prepaid dental
3 plan organization as defined in section 20-1001 may use as a medical director
4 either:

5 1. An individual who holds an active unrestricted license to practice
6 dentistry in this state pursuant to title 32, chapter 11.

7 2. A physician who holds an active unrestricted license to practice
8 medicine in this state pursuant to title 32, chapter 13 or 17.

9 D. For determinations made pursuant to subsection B of this section,
10 an optometric service corporation may use as a medical director either:

11 1. An individual who holds an active unrestricted license to practice
12 optometry in this state pursuant to title 32, chapter 16.

13 2. A physician who holds an active unrestricted license to practice
14 medicine in this state pursuant to title 32, chapter 13 or 17.

15 E. FOR DETERMINATIONS MADE PURSUANT TO SUBSECTION B OF THIS SECTION, A
16 HEALTH CARE INSURER MAY USE A CHIROPRACTOR LICENSED IN THIS STATE PURSUANT TO
17 TITLE 32, CHAPTER 8 OR BY ANY REGULATORY BOARD IN ANOTHER STATE TO REVIEW ANY
18 DIRECT DENIAL OF PRIOR AUTHORIZATION OF A CHIROPRACTIC SERVICE REQUESTED BY A
19 CHIROPRACTOR ON THE BASIS OF MEDICAL NECESSITY.